DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

REC'D MAR 19 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8428

Registration District No. 1121 Primary Registration District No. 6145 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County Texas
(b) City or town Jackson Rural Twp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Texas
(c) City or town Raymondville Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Rural
(If rural, give location)
(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME Jessie Oliver Shipp
3. (b) If veteran, name war 3. (c) Social Security No.

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced married
6. (b) Name of husband or wife Rob't Shipp
6. (c) Age of husband or wife if alive 77 years
7. Birth date of deceased Mar 19 1894 (Month) (Day) (Year)

8. AGE: Years 45 Months 11 Days 23 If less than one day hr. min.

9. Birthplace Licking (City, town, or county) Mo (State or foreign country)
10. Usual occupation House wife
11. Industry or business

FATHER
12. Name Wm McGuire
13. Birthplace Salt Lake City Utah (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Sarah Elizabeth Durham
15. Birthplace Johnson County, Illinois (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Robert McGuire
(b) Address Raymondville, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Mar 14-40 (Month) (Day) (Year)
(c) Place: burial or cremation Rock Springs Cem.
18. (a) Signature of funeral director Smith & Ferguson.
(b) Address Licking, Mo.
19. (a) Mar 13-1940 (Date received local registrar) (b) Mrs Dora Gregory (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 13 year 1940 hour 1 minute 02 A. M.

21. I hereby certify that I attended the deceased from Mar. 4 1940, to Mar 13 1940
that I last saw her alive on Mar. 11 1940
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death HEMORRHAGE FROM ESOPHAGEAL VARIX	5 MIN.
Due to CHRONIC CHOLCYSTITIS	
Due to	
Other conditions OBESITY (include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature J M Collins (M. D. or other) MD.
Address Houston Date signed 3-13-40

(Licensed Embalmer's Statement on Reverse Side)

50M-5-17-39
Rev. 5-17-39
I X12511

RECEIVED FILED STATE OFFICE
INDEX CARD RETURNED TO DISTRICT
DATE 3-24-40

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

5. No. 2B
—2-21-40
1 X22659

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 8428 X

Registration District No. ____ Primary Registration District No. ____ Registrar's No. ____

1. PLACE OF DEATH:
(a) County Texas
(b) City or town ____
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ____
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State ____ (b) County ____
(c) City or town ____
(If outside city or town limits write "RURAL")
(d) Street No. ____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME Jessie O. Phipps
3. (b) If veteran, name war ____
3. (c) Social Security No. ____

4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced M
6. (b) Name of husband or wife ____
6. (c) Age of husband, or wife, if alive ____ years
7. Birth date of deceased ____ (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
			hr. ____ min.

9. Birthplace ____ (City, town, or county) (State or foreign country)
10. Usual occupation ____
11. Industry or business ____

FATHER
12. Name ____
13. Birthplace ____ (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name ____
15. Birthplace ____ (City, town, or county) (State or foreign country)

16. (a) Informant ____
(b) Address ____
17. (a) ____ (Burial, cremation, or removal) (b) Date thereof ____ (Month) (Day) (Year)
(c) Place: burial or cremation ____
18. (a) Signature of funeral director ____
(b) Address ____
19. (a) ____ (Date received local registrar) (b) ____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. 13 day 4:0
year ____ hour ____ minute ____ M.
21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____;
that I last saw h____ alive on ____, 19____;
and that death occurred on the date and hour stated above.

SUPPLEMENTARY

Immediate cause of death	Duration
Hem orrhage	
from esophageal varix	
Due to Chr. Cholecystitis	
unable to add. further information	
Due to Obesity	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations ____
Of autopsy ____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(c) Where did injury occur? ____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature L. M. Dillman (M. D. or other)
Address Linton Date signed ____